U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 11 April 2006

CASE NO.: 2004-BLA-5756

In the Matter of:

CHARLES L. COURTNEY
Claimant

v.

CEDAR COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances

Roger D. Forman, Esq.
For the Claimant

David L. Yaussy, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This matter arises from a second claim for Black Lung Benefits filed on April 10, 2002.[1] (DX-3). I held a formal hearing in this case on August 9, 2005 in Charleston, West Virginia. At the hearing, I afforded all parties a full opportunity to present evidence and argument, as provided in the Act and Regulations. At the hearing, I admitted Claimant's Exhibits 1-12 and Employer's Exhibits 1-4 and 6-11 into evidence. (TR-14, 20).

[1] The Black Lung Benefits Act, as amended, is codified at 30 U.S.C. § 901 with its implementing regulations found at Title 20 of the Code of Federal Regulations. The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, TR = Transcript of the August 9, 2005 hearing, BCR = Board-certified radiologist, B = NIOSH-certified B-reader.

ISSUES

1. The length of coal mine employment;
2. Whether the evidence establishes a material change in condition of entitlement pursuant to § 725.309;
3. Whether Claimant has pneumoconiosis;
4. Whether Claimant's pneumoconiosis arose out of his coal mine employment;
5. Whether Claimant is totally disabled; and
6. Whether Claimant's total disability is due to pneumoconiosis.

(DX-23; TR-25).

The findings of fact and conclusions of law that follow are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Claimant, Charles L. Courtney, filed his first application for benefits on December 21, 1994. (DX-1, (DX-1)). The District Director found that Claimant was entitled to benefits. (DX-1, (DX-39)). Employer objected to the District Director's findings and requested a hearing before an Administrative Law Judge (ALJ). (DX-1, (DX-40)). ALJ Tierney issued his Decision and Order on January 14, 1998, based on a finding that the evidence did not establish that Claimant suffered from pneumoconiosis. (DX-1). Claimant appealed the decision to the Benefits Review Board (BRB), and on January 19, 1999, the BRB affirmed Judge Tierney's decision. (DX-1).

Claimant filed this subsequent claim for benefits with the Department of Labor (DOL) on April 10, 2002. (DX-3, TR-23). The District Director issued a Proposed Decision and Order on August 6, 2003, in which he allowed the claim, finding that Claimant established all elements to entitlement. (DX-19). On August 13, 2003, Employer objected to the findings of the District Director by stating that it wished to appeal the decision and request a hearing. (DX-20). This matter was transferred to the Office of Administrative Law Judges on February 11, 2004. (DX-23).

I held a formal hearing in this case on August 9, 2005 in Charleston, West Virginia. On September 26, 2005, I issued a Post-Hearing Order in which Director's Exhibits 1-25 were admitted into the record and which recorded Claimant's withdrawal of his Exhibit 8. On October 28, 2005, Employer submitted an October 17, 2005 report and an October 20, 2005 addendum report of Dr. Robert B. Altmeyer. I now admit these documents as Employer's Exhibit 12. On November 29, 2005, Employer submitted a deposition transcript of Dr. Donald L. Rasmussen, taken on October 25, 2005. I now admit this transcript as Employer's Exhibit 13. On December 14, 2005, I received the deposition transcript of Dr. Robert A.C. Cohen, taken on December 8, 2005. I now admit this transcript as Claimant's Exhibit 13.

On January 4, 2006, I received Claimant's brief, and on January 13, 2006, I received Employer's brief. Claimant's brief renews his motion to strike Employer's Exhibit 2.[2] My review of the parties' x-ray evidence in record reveals two medical record x-rays, two Director x-rays, three Employer x-rays, and two Claimant x-rays. Parties are entitled to submit no more than two x-rays in their affirmative cases and no more than one physician's interpretation of each chest x-ray submitted by the opposing party in their rebuttal cases. 20 C.F.R. § 725.414. Employer's Evidence Summary Sheet identified Dr. Wiot's reading of the 1-6-99 x-ray and Dr. Zaldivar's reading of the 5-28-03 x-ray as its affirmative evidence. Claimant's Evidence Summary Sheet identified both Dr. Ahmed's and Dr. Cappiello's readings of the 5-28-03 x-rays as being rebuttal x-rays. At the hearing, Employer identified a third x-ray, a reading by Dr. Wiot of a 2-11-03 x-ray, as being another affirmative x-ray. Upon objections from Claimant, Employer classified its x-ray evidence as follows: two x-ray interpretations by Dr. Wiot as affirmative evidence and Dr. Zaldivar's interpretation as rebuttal evidence. (TR-17).

Claimant argues Employer's Exhibit 2, Dr. Wiot's reading of the 2-11-03 x-ray, constitutes too many readings of too many x-rays. I find that Employer's submission of Dr. Zaldivar's interpretation is permissible after having undertaken a necessary reclassification of Claimant's exhibits. 20 C.F.R. § 725.414(a)(2)(ii) allows Claimant to submit, in rebuttal, "no more than one physician's interpretation of each chest x-ray . . . ." I note that Claimant's two x-rays are interpretations of the same 5-28-03 chest x-ray. Claimant is allowed to submit in rebuttal only one reread of each x-ray – not two rereads of one x-ray. Therefore, in an effort to allow in as much relevant evidence as possible and because Claimant did not submit any affirmative x-rays, I choose to reclassify Claimant's Exhibit 1 as if it were submitted as affirmative evidence. In doing so, all three x-rays submitted by Employer are admissible within evidentiary limitations. Employer identified Dr. Zaldivar's interpretation as being rebuttal evidence. (TR-17). This is permissible because one of Claimant's x-rays must be submitted as affirmative evidence in order for both x-rays to be admitted. Thus, Dr. Zaldivar's interpretation of the 5-28-03 x-ray is admissible as rebuttal evidence to Claimant's affirmative evidence. The chart below illustrates the reclassification of evidence.

	Original Classification	**Current Classification**
Dr. Wiot x-ray 1-6-99	Employer's affirmative - 1	Employer's affirmative -1
Dr. Wiot x-ray 2-11-03	(not identified)	Employer's affirmative -2
Dr. Zaldivar x-ray 5-28-03	Employer's affirmative -2	Employer's rebuttal -1
Dr. Ahmed x-ray 5-28-03	Claimant's rebuttal -1	Claimant's affirmative -1
Dr. Cappiello x-ray 5-28-03	Claimant's rebuttal -2	Claimant's rebuttal -1

Therefore, the evidence in the record includes Director's Exhibits 1-25, Claimant's Exhibits 1-7 and 9-13, and Employer's Exhibits 1-4 and 6-13.

[2] Claimant's brief also identified Employer's motion to strike Director's Exhibits, raised at hearing, as outstanding. I already addressed Employer's motion in my September 26, 2005 Post-Hearing Order in which I overruled Employer's motion and admitted Director's Exhibits into the record.

At the August 9, 2005 hearing, the parties stipulated that the application was filed April 10, 2002; that this subsequent claim was filed more than one year from the prior denial; that Cedar Coal Company is the Responsible Operator; and that Claimant has one dependent for purposes of augmentation, his wife Jerry Lou. (TR-23).

Length of Coal Mine Employment

Employer acknowledged that Claimant worked for Cedar Coal Company "a little less than ten" years. (TR-41). I find that the Social Security records establish an additional three years of coal mine employment prior to Claimant's employment with Cedar Coal Company. (DX-4). Thus, I find that Claimant was a coal miner within the meaning of the Act for at least 13 to 14 years between 1970 and 1984.

Responsible Operator

I find, and Cedar Coal Company agrees, that it is properly named as the Responsible Operator.[3] (TR-23).

Date of Filing

I find, and the parties agree, that Claimant filed this subsequent claim for benefits under the Act on April 10, 2002. (DX-2, TR-21, 23). This subsequent claim was filed more than one year following the denial in the previous claim. (TR-21).

Claimant's Testimony

At the hearing, Claimant testified that he was 78 years old and was married. (TR-24). Claimant testified that his last coal mine job was as a dozer operator. (TR-32). He described that the job was very dusty, and he would breathe in a lot of dust, including coal dust and sand dust. (TR-33). His job entailed operating the dozer, cleaning the tracks, fueling the dozer, and taking care of the dozer. (TR-33, 40-41). Claimant testified that it would be "pretty rough" for him to climb up into a dozer, and that even if he could operate a dozer, he would need to work in one that was air conditioned. (TR-40).

Claimant started smoking around 1942 and quit around 1980. (TR-36). Claimant testified that he typically smoked a pack a day but sometimes would smoke almost two packs per day.[4] (TR-36). Claimant's breathing problems prevented Claimant from doing much because he did not "have the wind to do it with." (TR-30). Claimant was on oxygen at night, and on hot

[3] Claimant's last coal mine employment was in West Virginia. The Benefits Review Board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989). Because Claimant's last coal mine employment took place in West Virginia, the jurisdiction of the United States Court of Appeals for the Fourth Circuit applies.

[4] There is some variation in the amount of smoking history as identified by the physicians. I find that a majority of the histories are consistent, as is Claimant's testimony, of a history of approximately 41 years at about 1 ½ packs per day. I find that Claimant did stop smoking around 1980.

days, he stays in the house on oxygen. (TR-32). Claimant testified that he had a heart catheterization and heart bypass surgery in 1997. (TR-39). Claimant stated, "I get along real good since then." (TR-39). When asked whether his breathing was better following the surgery, Claimant responded, "My mind tells me I can go but my breathing says I can't." (TR-39).

Subsequent Claim

Because this is Claimant's second claim and thus a subsequent claim, Claimant must prove that one of the applicable conditions of entitlement has changed since the denial of his prior claim. 20 C.F.R. § 725.309. I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

In this case, Claimant's most recent claim was denied by Judge Tierney on January 14, 1998 because Claimant failed to establish the threshold element that he suffered from pneumoconiosis and would be unable to establish any of the other elements. (DX-1). The BRB affirmed this decision on January 19, 1999. (DX-1). This claim was filed on April 10, 2002.

Because the present claim was denied on the basis that the Claimant failed to establish the threshold element that he suffered from pneumoconiosis and would be unable to establish any of the other elements, I will initially determine whether the evidence submitted since 1999 now establishes any of the elements of entitlement. If any element is established, then I will weigh all record evidence to determine if the Claimant has established all elements on the merits. Otherwise, the subsequent claim must be denied.

New Medical Evidence

Chest X-rays

Exhibit	**X-ray Date**	**X-ray Read**	**Physician/ Qualifications**	**Interpretation**
EX-7	1-1-1999	1-2-1999	Zekan*	some diffuse interstitial disease, poorly defined nodularity in upper zones bilaterally probably relating to old granulomatous process
EX-1	1-6-1999	5-29-04	Wiot – BCR/B	no evidence of pneumoconiosis, old granulomatous disease, quality 1
DX-10	7-23-02	7-23-02	Ranavaya – B	1/1, p/q, upper and mid zones bilaterally, quality 1
DX-10	7-23-02	10-11-02	Binns – BCR/B	Quality reading only – 1
CX-5	2-5-03	2-5-03	Quintero*	Patchy mixed interstitial infiltrate in right cardiophrenic angle, may be acute. Patchy reticular nodular changes in left apex, may suggest underlying chronic interstitial

				process, underlying probable COPD
EX-2[5]	2-11-03	5-29-04	Wiot – BCR/B	no evidence of pneumoconiosis, bronchiectasis, old granulomatous disease, quality 2
EX-10	5-28-03	7-7-03	Zaldivar – B	No parenchymal abnormalities consistent with pneumoconiosis, granulomas
CX-1,4	5-28-03	10-2-04	Ahmed – BCR/B	2/1, q/r, all zones, quality 1
CX-2,3	5-28-03	10-29-04	Cappiello – BCR/B	2/1, p/s, quality 2

* Medical record - x-ray not read for diagnosis of pneumoconiosis

CT Scans[6]

Dr. Enrico Cappiello read a chest CT scan dated December 8, 2004 at Claimant's request. His findings of the high resolution CT included advanced changes of chronic obstructive pulmonary disease; many small parenchymal opacities scattered in both lungs consistent with simple pneumoconiosis; some rounded and some irregular-shaped opacities; and opacities located in the four upper zones. Dr. Cappiello stated, "Perfusion classification would require a concomitant diagnostic chest x-ray fulfilling ILO standards category 1 or 2 in order to give the perfusion." Dr. Cappiello is board-certified in radiology and is a B-reader. (CX-10).

Dr. Afzal Ahmed read the December 8, 2004 CT scan at Claimant's request. His findings included changes of pneumoconiosis demonstrated by nodular densities in the upper lung fields, minimal posterior calcification of left pleura could be pneumoconiosis; underlying chronic obstructive pulmonary disease; bullae in both fields and scarring at lung bases; and nodules in both lung fields could be granulomatous process or may represent even metastatic disease. Dr. Ahmed is board-certified in radiology and is a B-reader. (CX-11).

Dr. Mary McJunkin read the December 8, 2004 CT scan at Employer's request. She noted somewhat emphysematous changes of the lungs and irregular density in the left upper lung which could be due to parenchymal scarring. Her impression was nonspecific mild interstitial fibrosis, minimal pleural thickening, minimal irregular pleural based density, and a speculated density in the left upper lung. Dr. McJunkin is a board-certified radiologist. (EX-4).

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[5] Dr. Wiot's 2-11-03 x-ray interpretation was accompanied by a "cover letter." This cover letter does not only accompany Dr. Wiot's interpretation but addresses three x-ray interpretations, one of which is not in the record, and responds to questions posed by Employer. I find Dr. Wiot's cover letter to be a report as defined in 20 C.F.R. § 725.414(a), and I disregard this letter as a report in excess of Employer's evidentiary limits.

[6] Since admission of the CT scan evidence into the record, the Benefits Review Board has issued their decision in *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-__, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc)(J. Boggs concurring). The Board found that although 20 C.F.R. § 725.107 provided no specific numeric limitations, "§ 718.107 (sic) is reasonably interpreted to allow for the submission, as part of a party's affirmative case, of one reading of each separate test or procedure undergone by claimant." *Id*. at 8. The Board did not state that its findings were to be applied retroactively to all cases wherein interpretations in excess of the new evidentiary limits were already admitted into the record. Therefore, I find that these interpretations were properly admitted at the time both parties submitted them to this court, and I find that the recent *Webber* decision does not require me to order either party to elect only one interpretation to remain in the record.

Dr. Jerome Wiot read the December 8, 2004 CT scan at Employer's request. He found no evidence of coal workers' pneumoconiosis. He noted the lung fields were over-expanded consistent with emphysema. Dr. Wiot is board-certified in radiology and is a B-reader. (EX-6).

Dr. J.M. Swalchick read a February 25, 2005 CT scan for purposes of treatment at the request of Claimant's physician, Dr. Perez. The report refers to a prior abnormal chest x-ray with COPD. Dr. Swalchick's impression was of hyperinflation with scant lung markings in the lower lobe mid lung distribution consistent with a panlobular emphysema; evidence of old granulomatous disease with calcification about the hila and punctuate nodules in both lung fields bilaterally, the tiny nodules remain indeterminate due to their small size; and a left adrenal mass, which likely represents a benign adenoma. (EX-9).

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV_1	FVC	MVV	FEV_1/FVC	Qualifying?
DX-10[7]	7/23/02	68"	75	1.27 1.25*	2.26 2.50*	---- ----	56% 49.9%*	No Yes
EX-3	5/28/03	68"	76	1.50 1.60*	2.63 2.60*	---- ----	57% 62%*	No No

* Post-bronchodilator value

Blood Gas Studies

Exhibit	Date	PCO2	PO2	Qualifying?
DX-10	7/23/02	34	63	Yes
EX-10	5/28/03	36 34*	62 64*	Yes Yes

* Post-exercise result

Physician Opinion Evidence

Dr. Robert Crisalli

Dr. Crisalli sent a letter dated April 18, 2002 to Claimant stating that he had been treating Claimant for COPD and CWP. He noted that he had made these diagnoses based on Claimant's history and chest x-rays. (DX-9). Dr. Crisalli is board-certified in pulmonary diseases and internal medicine. (DX-19).

Dr. Mohammed T. Ranavaya

Dr. Ranavaya performed an examination of Claimant on behalf of the Department of Labor on September 23, 2002. He noted Claimant's work history of 15 years, smoke history of ½ pack per year for 41 years, and symptoms. The symptoms included, among other things, morning sputum which was thick and gray; wheezing while lying down and on exertion; daily

[7] By report dated October, 26, 2002, Dr. Gaziano found the pulmonary function test and the blood gas study to be acceptable. (DX-10).

severe dyspnea; daily dry, severe cough; occasional hemoptysis; ankle edema; and occasional paroxysmal nocturnal dyspnea. Dr. Ranavaya recorded that Claimant also complained of experiencing shortness of breath upon mild to moderate exertion; could walk approximately 100 feet of level ground or 20 feet of incline before becoming winded; and could only do about 10 steps before becoming winded. Dr. Ranavaya's exam of Claimant revealed the following: percussion – minimum hyperresonance mainly in apices and auscultation – mildly prolonged expiration phase with minimum decreased breath sounds all over with few scattered rhonchi.

Dr. Ranavaya concluded that Claimant suffers from pneumoconiosis based upon Claimant's work history and positive chest x-ray. He also diagnosed coronary artery disease based upon Claimant's history. Dr. Ranavaya also found Claimant to suffer from moderate impairment and moderate hypoxemia at rest. He opined that Claimant's impairment was caused "to a major extent" by his pneumoconiosis. According to the Medical Evidence - Initial Finding of the District Director, Dr. Ranavaya is board-certified in internal medicine and is a B-reader. (DX-10, 19).

Dr. George L. Zaldivar

Dr. Zaldivar examined Claimant on May 28, 2003 and prepared a report dated July 7, 2003 at the request of Employer. After extensive review of Claimant's medical records and prior x-rays, Dr. Zaldivar concluded that the radiographic abnormalities are most compatible with calcified and partially calcified granulomas from old infection, most typically histoplasmosis, and that Claimant did not have CWP. Dr. Zaldivar stated, "The radiographic findings could be those of pneumoconiosis mixed with an old infection such as histoplasmosis, but the predominant densities are those of granulomas and not pneumoconiosis." He concluded that breathing tests from 1986 showed that Claimant's test results were normal when quitting the mines but that Claimant now had severe emphysema. Dr. Zaldivar also opined that Claimant was severely disabled from a pulmonary standpoint, which was the result of smoking and unrelated to his coal mine work.[8] Dr. Zaldivar concluded that even if Claimant were found to have macules of CWP, his opinion regarding the cause of pulmonary impairment would remain the same. (EX-10).

Dr. Zaldivar prepared a second report dated July 5, 2005 in which he noted that Claimant began smoking at a young age when the lungs are still forming. Dr. Zaldivar opined that the introduction of chemicals during development would have a long lasting consequence to the lungs, and based on a 1995 carbon monoxide level in Claimant's blood, he believed Claimant was still smoking through 1995. Dr. Zaldivar's opinion was that damage to Claimant's lungs as a result of a "lifelong smoking habit." Dr. Zaldivar opined that cessation of smoking does not stop the damage, but that "[i]f the damage has occurred, it will become more evident as the individual ages . . . ." He concluded that Claimant suffered the pulmonary effect of emphysema caused by his lifelong smoking history and aggravated by an asthmatic condition produced by

[8] Although consistent in the number of years that Claimant worked (15 years), Dr. Zaldivar does refer to Claimant's quitting of the mines variously between 1984 and 1975, e.g., Dr. Zaldivar stated, "Such emphysema was not present in 1986, eleven years after having quit the mines . . . .", "In 1975 the company closed down. He quit work.", and This [11/18/1978] x-ray was taken three years after Mr. Courtney quit the coal mines." (EX-10).

this same tobacco smoke. He opined that the damage was due to emphysema caused by smoking, that Claimant did not suffer from coal workers' pneumoconiosis, and that he did not suffer from any pulmonary conditions caused by his work in the coal mines. While noting a disabling pulmonary impairment that prevented Claimant from performing his usual coal mine work, Dr. Zaldivar concluded this impairment was not the result of pneumoconiosis but rather of a lifelong history of smoking which began in his preteen years. Dr. Zaldivar is board-certified in internal medicine and pulmonary disease, is a certified sleep disorders specialist, and is a certified B-reader. (DX-3).

Dr. Robert A.C. Cohen

Dr. Cohen prepared a report dated November 13, 2004 at the request of Claimant. He reviewed reports, records, and x-ray and test results. Dr. Cohen opined that Claimant did have pneumoconiosis based on the sum of Claimant's history, symptoms, test results, and x-ray results. Dr. Cohen opined that even if the sum of the x-ray evidence was later deemed to be negative for pneumoconiosis, he would not change his opinion that Claimant had substantial historical, physical, and physiological evidence of CWP related to his coal mine dust exposure.

Dr. Cohen noted that the data from the pulmonary function and cardiopulmonary exercise tests show that Claimant has moderate obstructive lung disease with hypoxemia. Dr. Cohen believed that coal mine dust exposure was a significant contributing cause of Claimant's pulmonary dysfunction including moderate obstructive lung disease, diffusion impairment, and gas exchange abnormalities at rest and with exercise. Dr. Cohen referenced several studies and publications to support his conclusion that Claimant's obstructive lung disease was caused in part by coal mine dust exposure. Dr. Cohen also believed that tobacco smoke exposure was a significant contributing factor. He concluded that this impairment was severe enough to preclude Claimant from engaging in physical exertion required for his coal mine employment. Dr. Cohen noted that Claimant would be unable to tolerate the dusty atmosphere or perform the physical labor required of his last coal mine employment.

Dr. Cohen testified at a deposition on December 8, 2005. Since preparing his report of November 13, 2004, Dr. Cohen had reviewed several CT scan interpretations, reports of Drs. Zaldivar and Altmeyer, and "a few other items." (CX-13 at 6). Dr. Cohen noted that the recently reviewed evidence did not change his opinion in any substantive way. (*Id.* at 7). Dr. Cohen addressed Dr. Altmeyer's opinion that a majority of pulmonologists agree that in the absence of positive chest imaging there would be no findings of possible contributions based on coal mine dust exposure. He stated that this was not accurate at all and provided a number of studies that evidenced the contrary, namely, "that patients with significant coal mine dust exposure, even absent chest x-ray findings, have been shown to have significant relationship between that exposure and lung function impairment." (*Id.* at 11). Dr. Cohen acknowledged that there was no specific test, absent pathology, that could allow a physician to determine which toxin (cigarette smoke or coal mine dust) caused impairment and that both toxins cause similar types of damage in the lungs. (*Id.* at 14). However, Dr. Cohen did note, "with coal mine dust, silica as opposed to tobacco, is that the dust is retained in the lung." (*Id.* at 15). Thus, coal mine dust and silica cause progression even after exposure ceases. Dr. Cohen noted, "the literature

shows that loss of lung function after smoking cessation reverts to a normal rate of decline [as someone who doesn't smoke] and doesn't stay at an excessive rate of decline." (*Id.* at 17). Dr. Cohen opined that because Claimant stopped smoking prior to quitting work in the coal mine and because his pulmonary test results worsened since that time, "one could certainly say that a portion of that, if not all of it, was due to his occupational exposure as opposed to tobacco smoke." (*Id.* at 16).

Dr. Cohen then addressed the studies he relied upon in his November 13, 2004 report. Dr. Cohen noted that some of the studies he cited to were published in the premier journals on pulmonary medicine which had very stringent review rules that would have prevented the publication if the studies were flawed. (*Id.* at 21). Dr. Cohen criticized Dr. Zaldivar's own publications as being biased and skewed on a selection basis, whereas the other studies were done on a national level (both within the United States and within Britain) by objective occupational epidemiologists with randomly selected miners. (*Id.* at 22-3). Dr. Cohen stated, "I think that smoking was a very important and very significant contribution to his obstructive lung disease, but his occupational exposure was also significantly contributory and had an effect." (*Id.* at 25). He continued, "You cannot completely discount this occupational exposure, especially considering that this man developed the disease and that he did stop smoking . . . shortly after or before he stopped mining." (*Id.* at 25). Dr. Cohen has extensive credentials, both nationally and internationally, in pulmonary medicine, particularly in the area of occupational medicine and black lung. He is board-certified in internal medicine, pulmonary disease, and critical care medicine, and Dr. Cohen is a certified B-reader. (CX-6, 7).

Dr. Robert B. Altmeyer

Dr. Altmeyer prepared a report dated July 9, 2005 at the request of Employer. After extensive review of medical, x-ray, and CT reports, Dr. Altmeyer provided his opinion. He opined, "[i]t is very likely that [Claimant] did not have pneumoconiosis." This conclusion was based on (1) CT scan findings that nodules are more consistent with healed histoplasmosis than CWP, (2) a 1972 x-ray which is not in the record, (3) physiological abnormalities in airflow obstruction which are consistent with the effects of long-term tobacco smoking, and (4) a 1986 FEV1 finding which is not in the record. Dr. Altmeyer concluded that Claimant had a severe airflow obstruction that prevented him from performing his last coal mine job. Dr. Altmeyer stated, "[Claimant] has not developed any of the diseases known to occur from the inhalation of dust in coal mines; therefore, he cannot have any impairment due to diseases which have not been shown to exist in these records." Dr. Altmeyer rebutted, "It remains my opinion that coal miners who have no evidence of coal workers' pneumoconiosis or silicosis by chest x-ray or CAT scan, if they have any respiratory impairment from the inhalation of coal dust, it would be quite small and not clinically significant and not of such a degree that it would constitute a disabling impairment." (EX-11).

Dr. Altmeyer prepared a second report dated October 17, 2005 which specifically addressed Dr. Rasmussen's October 12, 2005 report. Dr. Altmeyer reasserted his opinion, "coal workers' pneumoconiosis which is too mild to show up radiologically has never been shown to be associated with any clinically significant degree of airways obstruction." Dr. Altmeyer noted that loss of lung function from inhalation of coal dust would not progress to this severe degree

without additional exposure whereas it was common for individuals who smoke to have progressive loss of lung function even after they stop smoking. He opined that any respiratory impairment caused from coal dust exposure would not exceed 10 to 15% of reduction from expected spirometry values. Dr. Altmeyer stated, "It remains my opinion that it is highly unlikely that this man's progressive loss of lung function was due to exposure of free crystalline silica or coal dust . . . ." (EX-12).

Dr. Altmeyer added an addendum dated October 20, 2005 to his second report. He stated the 10 – 15% reduction from expected spirometric values was based on epidemiologic studies. However, he noted that this is small and would not lead to a clinically significant degree of impairment. Furthermore, he noted there is no specific test which would make a definitive differentiation which would allow one to ascribe airways obstruction to dust exposure or for that matter cigarette smoking. In concluding that it was highly unlikely that any significant proportion of his airflow obstruction was the result of silica exposure, he stated:

> Despite the fact that I feel that some of the reduction from expected spirometric values in this individual case may be due to the effect of silica exposure, there is not a specific way that I can prove reduction from expected values due to the inhalation of coal dust or silica dust. I am entertaining that possibility only on the basis of epidemiologic studies which are very difficult to apply in this case.

(EX-12). Dr. Altmeyer is board-certified in internal medicine and certified in the subspecialty of pulmonary medicine. Also, Dr. Altmeyer is a certified B-reader.

Dr. D.L. Rasmussen

Dr. Rasmussen prepared a report dated July 25, 2005 at the request of Claimant. In preparation for his report, he reviewed reports from Drs. Altmeyer, Zaldivar, and Cohen and the medical records of Dr. Perez. Dr. Rasmussen addressed the conflicting opinions on etiology of Claimant's impairment. Dr. Rasmussen criticized Dr. Zaldivar's attack of the medical studies relied upon by Dr. Cohen. Dr. Rasmussen stated that Dr. Zaldivar's position that these studies were invalid does not provide an explanation or proof against the conclusion that coal mine dust is capable of producing impairment in lung function absent cigarette smoking. Dr. Rasmussen stated, "[t]here is no evidence from the medical literature to support the concept that coal mine dust causes impairment only in the presence of considerable radiographic changes." Furthermore, Dr. Rasmussen criticized Dr. Zaldivar's attempt to impeach the credibility of Claimant when he stated that smoking histories are always unreliable and inaccurate.

Dr. Rasmussen provided medical studies contradicting Dr. Zaldivar's position on the potency of cigarette smoking and coal mine dust exposure. Finally, Dr. Rasmussen concluded that there was "no justification for the conclusion that [Claimant's] continued loss of lung function following his termination of coal mine employment was a consequence of continued smoking since there is no evidence to suggest that he did continue smoking after 1981." He concluded that cigarette smoking was a major cause of Claimant's disabling lung disease but also included coal mine dust exposure as a having contributed significantly.

Dr. Rasmussen testified at a deposition on October 25, 2005. He testified that although he had training in respiratory medicine, he never took the examination for board certification. (EX-13 at 4). Dr. Rasmussen noted that an appearance of a lot of calcified nodules would more likely mean granulomas but could not totally rule out pneumoconiosis. (*Id.* at 11). Dr. Rasmussen addressed that it was his assumption as to the amount of dust in the air and that Claimant's exposure was mostly silicon dioxide as that is the predominant particle found in overburden surface mining dust. (*Id.* at 12).

Dr. Rasmussen's testimony sets forth his positions that while both coal mine dust exposure and cigarette smoke can cause pulmonary impairment, cigarette smoke is more potent; both cigarette smoke exposure and coal mine dust exposure cause similar pulmonary problems and there is no way to distinguish between the pulmonary impairment caused by cigarette smoke exposure from that caused by coal mine dust exposure; and that either Claimant's history of cigarette smoke or Claimant's history of coal mine dust exposure could have caused Claimant's entire pulmonary impairment in and of itself. (*Id.* at 17 – 27). Dr. Rasmussen testified that pulmonary impairment can progress even after ceasing exposure to coal mine dust. Furthermore, he stated that it was his belief that pulmonary impairment from smoking can also progress after cessation of smoking; however, there is a much slower progression after cessation. (*Id.* at 27).

Dr. Rasmussen concluded that cigarette smoke was a major cause and that coal mine dust exposure contributed significantly to Claimant's pulmonary impairment based on his experience and evidence from epidemiologic studies. However, epidemiological studies would not necessarily provide guidance as to what happened in any particular case. (*Id.* at 31). Finally, Dr. Rasmussen stated, "None of the epidemiological studies say that as impairment in function progresses, that you necessarily have to have radiographic change in pattern – changes to match." (*Id.* at 34). Dr. Rasmussen is board-certified in internal medicine and forensic medicine. He is a B-reader. He has extensive experience is working in pulmonary medicine in West Virginia and has been appointed to several positions relating to coal workers' pneumoconiosis. (CX-12).

Medical Records

Dr. Juan J. Perez

Claimant was treated by Dr. Perez in Florida in February 2003. Complaints of wheezing and shortness of breath were recorded. Record dated February 12, 2003 noted the following assessment/plan:

1. COPD. Severe. Continue bronchodilators aggressively.
2. Nocturnal hypoxemia documented on overnight oximetry done 2/11/2203. I have discussed this with him. I have recommended we put him on oxygen nocturnally. He has agreed. I have written a prescription.
3. Black lung. Continue same medications.
4. Status post pneumonia. His x-ray has totally cleared up. I have recommended that we repeat x-rays every six months.

(CX-5).

Claimant saw Dr. Perez again on March 15, 2005. Claimant stated the he was feeling better and denied having any chest pains. Dr. Perez reviewed a CT scan dated February 25, 2005, which revealed multiple abnormalities most of which are chronic. Dr. Perez recommended having repeat CT scans ever four to six months for the next two years. He reviewed PFTs, which showed an FEV1 of 1.23l. Dr. Perez recommended that Claimant stay on bronchodilators at all times. His assessment/plan was as follows:

1. COPD, emphysematous type. Continue bronchodilators. Use steroids on an [as needed] basis.
2. Multiple abnormalities on CT scan . . .

(EX-8).

Charleston Area Medical Center

Dr. John F. Mega read an x-ray at the request of Claimant's treating physician, Dr. Robert J. Crisalli. Dr. Mega compared the x-ray to one dated August 26, 2003. He noted patient was status post CABG (coronary artery bypass graft) and that the heart and pulmonary vasculature were within normal limits. He found reticular nodular fibrosis demonstrated predominantly about the upper lobes. Dr. Mega opined this as unchanged compatible with the history of coal workers' pneumoconiosis. He also found COPD. (CX-9).

Change in Condition of Entitlement

As the present claim is Miner's second claim for benefits, and as it was filed more than one year after the denial of Miner's prior claim, the evidence must demonstrate that one of the applicable conditions of entitlement has changed since the date the prior denial become final. This claim was filed after January 19, 2001 and is governed by the amended regulations.

This claim must be adjudicated under the regulations at 20 C.F.R. § 718 because it was filed after March 31, 1980. Under this Section, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Existence of Pneumoconiosis

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)-(4). Claimant does not have any biopsy evidence and is not eligible for the presumptions.[9] In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the

[9] Claimant is ineligible for the § 718.304 presumption because he has not been diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is ineligible for the § 718.306 presumption because Claimant is still living.

miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. 20 C.F.R. § 718.202(a)(1). The x-ray interpretations of physicians who are board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

Of the nine x-ray interpretations admitted as newly submitted medical evidence, two x-rays were interpreted in conjunction with medical treatment, one was read for quality purposes only, three are negative, and three are positive. Because the two x-rays interpreted for purposes of medical treatment were not read for the existence of pneumoconiosis and because I do not have the readers' credentials, I assign little weight to their conclusions. Of the six x-rays read for the purposes of establishing the existence of pneumoconiosis, four were interpreted by dually-qualified board-certified radiologists and B-readers: Drs. Wiot, Ahmed, and Cappiello. Drs. Ranavaya and Zaldivar are B-readers but not certified in radiology. The three negative x-rays were interpreted by Dr. Wiot and Dr. Zaldivar. Dr. Wiot concluded the 1-6-99 and 2-11-03 x-rays showed old granulomatous disease and not pneumoconiosis. Dr. Zaldivar concluded that 5-28-03 x-ray showed granulomas and was not consistent with pneumoconiosis. The three positive x-rays were read as follows: Dr. Ranavaya read the 7-23-02 x-ray as 1/1, Dr. Ahmed read the 5-28-03 x-ray as 2/1, and Dr. Cappiello also read the 5-28-03 x-ray as 2/1.

I find that the x-ray evidence is in equipoise. By giving greater credit to the dually-qualified readings, disregarding Dr. Zaldivar's negative reading in light of two dually-qualified positive readings, considering Dr. Ranavaya's reading to a small degree, and taking note of the medical record x-rays, I conclude that the evidence does not preponderate toward or against a finding of pneumoconiosis. Therefore, Claimant has failed to establish that he suffers from pneumoconiosis based upon x-ray evidence.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). "Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion." 20 C.F.R. § 718.202(a)(4).

There are five CT scan interpretations in the record of newly submitted medical evidence. Of the five, four interpretations are of a 12-8-04 CT scan and one is of a 2-25-05 CT scan. All four interpretations of the 12-8-04 CT scan were done for purposes of determining the existence of pneumoconiosis. The 2005 CT scan was interpreted at the request of Claimant's physician, Dr. Perez. I have not been provided with credentials for Dr. Swalchick and as her interpretation was not done for the purposes of determining the existence of pneumoconiosis, I assign little weight to her interpretation. Of the four remaining CT interpretations, two are positive for the existence of pneumoconiosis and two are negative. The two positive interpretations were performed by dually-qualified board-certified radiologists and B-readers. The two negative

interpretations were read by Dr. Wiot, who is dually-qualified, and Dr. McJunkin, who is a board certified radiologist. In *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885, 892 (7th Cir. 2002), the court stated, "the Department [of Labor] has flatly refused to conclude that a negative CT scan is a wildcard that must trump all other evidence." Having taken the five interpretations into consideration both numerically and based on the readers' credentials, I find that the CT scan evidence is in equipoise. Therefore, Claimant has failed to establish pneumoconiosis based upon the CT scan evidence.

There are six physicians who prepared reports for this matter: Drs. Crisalli, Ranavaya, Zaldivar, Altmeyer, Cohen, and Rasmussen. Of these physicians, Dr. Crisalli is Claimant's treating physician, and Dr. Ranavaya examined Claimant at the request of the DOL. Drs. Zaldivar and Altmeyer did not find pneumoconiosis; the other physicians all diagnosed pneumoconiosis. Although Dr. Crisalli is Claimant's treating physician, his letter does not constitute a reasoned and documented report under the requirements of 20 C.F.R. § 718.104(a). Thus, I credit little weight to his opinion. Also, although Dr. Ranavaya's opinion is well documented in his review of Claimant's history, symptoms, and test results, Dr. Ranavaya did not have the opportunity to review Claimant's medical history or subsequent reports to evaluate how his diagnosis correlates to the findings by other physicians. Furthermore, Dr. Ranavaya provided only cursory reasoning for how he arrived at his conclusions. Thus, I assign less weight to his opinion.

I find Dr. Zaldivar's conclusions questionable because of his finding that Claimant continued to smoke at least through 1995 when I find that Claimant stopped smoking around 1980 and that he does not consistently record Claimant's mining history as ending in 1984 and refers to Claimant having stopped mining in 1975 on several occasions. *See* Footnote 8 *supra*. I believe that Dr. Zaldivar factored in Claimant's mining history and smoking history in making his conclusion, and I find that Dr. Zaldivar's frequent misstatements of Claimant's mining history and smoking history render his opinion unreliable. It is likely that Dr. Zaldivar attributed Claimant with having smoked for 20 years after he quit mining, which is inconsistent with my finding that Claimant stopped smoking a few years before he stopped mining. Therefore, I find Dr. Zaldivar's opinion to be unreliable and assign little weight to it.[10]

Dr. Altmeyer opines that Claimant would have needed additional exposure to silica in order for Claimant's impairment to progress to this level of severity whereas it is common for impairment from smoking to progress after cessation of smoking. It appears that Dr. Altmeyer failed to consider the progressive and latent nature of pneumoconiosis in making this conclusion because his conclusion stated that he relied on a normal 1986 pulmonary function study as evidence that the subsequent reduction in lung function was not the effect of inhalation of dust in coal mines. However, Dr. Altmeyer's opinion eventually acknowledges that a portion of the reduction in spirometric values is due to the effect of silica exposure, but he concludes that it is "highly unlikely" that it amounts to a significant proportion.

[10] Although Dr. Zaldivar stated that Claimant's smoking during the years when his lungs were still forming would have lasting consequences, he did not explain what "lasting consequences" meant. Dr. Zaldivar refers to an "interference with the development of his lungs" but does not describe how this interference might manifest later in Claimant's life. Without further explanation, I cannot find that this means anything other than that Claimant's lungs would be weakened and more susceptible to impairment from exposure to all forms of toxins.

Dr. Altmeyer also opined that miners without radiographic evidence of CWP could only have a small and clinically insignificant impairment, if any, that was caused by coal mine dust exposure. This statement was refuted by both Dr. Rasmussen and Dr. Cohen who provided citations to studies to evidence the contrary. The 10-15% reduction of spirometric values noted by Dr. Altmeyer was acknowledged by the studies cited by Drs. Rasmussen and Cohen.

For purposes of the Act, "legal pneumoconiosis" includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(a)(3). The general agreement among reports is that smoking caused at least a significant portion of Claimant's impairment. I find that the three physicians entitled to the most weight agree that a portion of Claimant's pulmonary impairment also is caused from coal mine dust exposure. Dr. Altmeyer opines, somewhat equivocally, that "it is highly unlikely" that it is a signification proportion. Drs. Cohen and Rasmussen agree that coal mine dust exposure contributed significantly.

Drs. Cohen and Rasmussen agreed with Dr. Altmeyer that no test, absent pathology, could determine which toxin caused impairment. However, Dr. Cohen opines that the progression of Claimant's impairment following cessation of smoking in 1980 and cessation of mining in 1985 is evidence that a portion of Claimant's impairment is caused from coal mine dust exposure. He stated that silica dust remains in the lungs unlike tobacco, which is the reason coal mine dust and silica can cause progression even after exposure ceases. However, Dr. Rasmussen stated that pulmonary impairment from smoking also can progress after cessation of smoking. However, Dr. Rasmussen did state that the level of progression would slow after cessation of smoking. Dr. Altmeyer, as stated above, does not appear to consider the progressive and latent nature of pneumoconiosis but agrees that impairment from smoking can progress after cessation of smoking. Because I find that Dr. Altmeyer failed to consider the progressive nature of pneumoconiosis, I credit Drs. Cohen's and Rasmussen's opinions with greater weight. While Drs. Cohen and Rasmussen disagreed over the possibility of progression in impairment from smoking, I note that both opine that coal mine dust exposure contributed significantly to Claimant's impairment. Thus, I find the weight of the evidence supports a finding of legal pneumoconiosis.

Pursuant to the holding in *Island Creek Coal Co.*, I must weigh all of the evidence under 20 C.F.R. § 718.202(a) together in determining whether Claimant has established pneumoconiosis. I find that Claimant has not established the existence of pneumoconiosis through the radiological evidence. Also, I find that the CT scan evidence does not support a finding of CWP. However, I find that the medical report and testimony evidence supports a finding of legal pneumoconiosis. Finding the x-ray and CT scan evidence to be in equipoise and the medical report evidence to preponderate toward a finding of legal pneumoconiosis, I find that the great weight of the evidence does support a finding that Claimant has legal pneumoconiosis.

Therefore, after weighing all of the evidence together, I find that Claimant has met his burden of establishing the existence of pneumoconiosis. As Claimant has demonstrated through reasoned medical opinion that he suffers from pneumoconiosis, he has therefore demonstrated a

change in condition pursuant to 20 C.F.R. § 725.309(d) and *Lisa Lee Mines*. On that basis, I will consider all the evidence to determine whether Claimant is entitled to benefits under the Act.

Existence of Pneumoconiosis

As stated above, Claimant can establish pneumoconiosis through one of four methods: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)-(4). In evaluating all x-ray evidence submitted both in the prior claim and in this subsequent claim, I find that Claimant is not been able to establish clinical pneumoconiosis by a preponderance of the evidence. As noted above, there is not biopsy evidence and the presumptions do not apply to this case. ALJ Tierney found that the medical report evidence in the prior claim did not establish pneumoconiosis while I find that the newly submitted evidence does support a finding of legal pneumoconiosis.

In weighing all the evidence together, I place greater weight on the more recently submitted medical reports as they address the progression of impairment that has occurred since the 1994 claim. In the prior claim, Dr. Zaldivar and Dr. Lockey agreed that Claimant was not disabled from performing his job as a dozer operator. In Dr. Zaldivar's current reports, he finds that Claimant is severely disabled from a pulmonary standpoint. Therefore, I find the more recently submitted medical evidence to be more consistent with Claimant's current condition and more relevant to my evaluation of the elements necessary for entitlement of benefits. I find that the weight of the medical report evidence supports a finding that Claimant currently suffers from legal pneumoconiosis.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the disease arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). Claimant was employed in the coal mines for at least 13 to 14 years, thus he is entitled to the rebuttable presumption that his pneumoconiosis arose out of coal mine employment.

Employer's physicians did not diagnose pneumoconiosis which is contrary to my findings. Thus, I credit little weight to their opinions regarding etiology. Furthermore, in finding that Claimant suffers from legal pneumoconiosis, I find that Claimant's pulmonary impairment is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(a)(3). I find that Employer has not presented sufficient evidence to rebut the presumption that the pneumoconiosis arose out of coal mine employment.

Evidence of Total Disability

A miner shall be considered totally disabled if the irrebutable presumption in § 718.304 applies. If that presumption does not apply, then a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. 20 C.F.R. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right-sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. 20 C.F.R. § 718.204(b)(2).

Claimant is not eligible for the irrebutable presumption in § 718.304 because he has not been diagnosed with complicated pneumoconiosis.

Claimant's blood gas studies produce qualifying results evidencing total disability. Furthermore, Drs. Ranavaya, Zaldivar, Cohen, Altmeyer, and Rasmussen agree that Claimant suffers from a severely disabling pulmonary impairment which precludes him from performing his last coal mine job. I find there is sufficient evidence establishing that Claimant is totally disabled.

Causation of Total Disability

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's totally disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. § 718.204(c)(1).

Dr. Zaldivar opined that pulmonary impairment was caused entirely by Claimant's smoking history; Dr. Altmeyer opined that it was highly unlikely that any significant proportion of Claimant's airflow obstruction was caused by Claimant's exposure to coal mine dust. Because these opinions are contrary to my finding of legal pneumoconiosis, I credit little weight to their opinions in determining whether Claimant's pneumoconiosis was a substantially contributing cause of his total disability. Dr. Ranavaya found that Claimant's impairment was caused to a major extent by pneumoconiosis. Drs. Cohen and Rasmussen opined that smoking was a significant cause of Claimant's pulmonary impairment but that coal mine dust exposure was also a significant contributing cause. Weighing these opinions and my finding of legal pneumoconiosis, I find that a preponderance of the evidence establishes that pneumoconiosis is a substantially contributing cause of Claimant's total disability.

CONCLUSION

Because Claimant has established all elements of entitlement, I conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case where the evidence does not establish the month of onset of total disability due to pneumoconiosis, benefits are payable beginning with the first day of the month during which the claim was filed. In the instant matter, Claimant filed this claim on April 10, 2002. (DX-3).

Attorney's Fee

No award of attorney's fees for services to the Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application; his attention is directed to 20 C.F.R. §§ 725.365 and 725.366. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of Charles L. Courtney for Black Lung benefits under the Act is hereby GRANTED, and

It is hereby ORDERED that Cedar Coal Company, the Responsible Operator, shall pay to the Claimant, Charles L. Courtney, all augmented benefits to which he is entitled under the Act, commencing April 1, 2002.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).